TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
YS ORTHOPEDICS PLLC

Respondent Name
NORTH RIVER INSURANCE CO

MFDR Tracking Number
M4-15-3606-01

Carrier's Austin Representative
Box Number 53

MFDR Date Received
July 01, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This letter is to request a review of a workers compensation claim pursuant to the Texas Workers Compensation Fee Schedule. The Texas Workers Compensation Medical Fee Schedule is promulgated by Title 28 of the Texas Administrative Code and is used to calculate payment of medical services required to treat work related injuries and illnesses.

Our review of the applicable guidelines for medical services, charges and payments does not reveal justification for non-payment on this claim. We do not believe the claim has been properly reviewed based on Texas Administrative Code, Title 28, Part 2, Chapter 134, Subchapter F, Rule §134.503 and require an explanation regarding which portion of the Texas Workers Compensation Medical Fee Schedule was used to determine the payment amount and how conversion factors, if applicable, were determined and applied. Please be advised, Title 28 of the Texas Administrative Code provides the following under Section 134.503(c)(1)."

Amount in Dispute: $890.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This firm has been retained to represent the Carrier in the above-referenced matter. Please direct all further communication to the undersigned. Enclosed please find documents responsive to this issue for you review. I am filing the DWC-60 Form on behalf of the above-referenced Carrier in response to the request for fee reimbursement for date of service of June 4, 2014. I am attaching 6 pages of responsive documents.

Provider has waived its right to MDR. This request for medical dispute resolution should be dismissed because it was not filed within one year of the date of service. The date if service is June 4, 2014. This request was filed on July 1, 2015. Rule 133.307 (c)(1)(A) states as follows: "A request for MDFR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The exceptions do not apply; therefore, provider had one year deadline. Since provider missed the deadline Carrier requests the Division dismiss this request for medical fee dispute resolution."

Response Submitted by: Hoffman Kelly 5316 HWY 290 West, Suite 360 Austin, TX 78735

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 04, 2014	CPT Code J3490	$890.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - AE – The service is excluded from the physician fee schedule
   - CBRS – Complex Surgical/Anesthesia bill review
   - D22 – Reimbursement was adjusted for the reason to be provided in separate correspondence
   - TX-W1 – Workers Compensation State Fee Schedule Adjustment

Issues

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states:

> Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section.
>
> (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.

The date of the service in dispute is June 04, 2014. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on July 01, 2015. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		8/4/15
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.